**ANCILLARY PARTICIPATION AGREEMENT**

**STATE: KENTUCKY**

**COVER SHEET**

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| **Creation Date:** | |
| **Icertis Contract Number:** | **Merlin ID:** |
| **Provider Name:**<br>**Legal Name:**<br><br>**DBA Name:** | |

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| **Federal Tax ID:**<br>**EIN: ICM Tax ID** |

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| **Optional Information:**<br>**NPI:** |

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| **Contract Contact Information:**<br>**Name:** |

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# ANCILLARY PROVIDER PARTICIPATION AGREEMENT

This Ancillary Provider Participation Agreement ("**Agreement**") is made and entered into by and between the party named on the signature page below (hereinafter referred to as "**Provider**") and Humana Health Plan, Inc., Humana Health Plan of Ohio, Inc., and Humana Insurance Company of Kentucky and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**").

## RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, **Humana** and **Provider**, and their respective employees and agents, are at all times acting and performing as independent contractors, and neither party, nor their respective employees and agents, shall be considered the partner, agent, servant, employee of, or joint venturer with, the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither **Provider** nor **Humana** will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage to persons or property. Notwithstanding anything to the contrary contained herein, **Provider** further agrees to and hereby does indemnify, defend and hold harmless **Humana** from any and all claims, judgments, costs, liabilities, damages and expenses whatsoever, including reasonable attorneys' fees, arising from any acts or omissions in the provision by **Provider** of Health Care Services to Members. This provision shall survive termination or expiration of this Agreement.

1.2 The parties agree that **Humana's** affiliates whose Members receive services hereunder do not assume joint responsibility or liability between or among such affiliates for the acts or omissions of such other affiliates.

## SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for professional medical service and/or related Health Care Services to individuals designated by **Humana** (herein referred to as "**Members**") with an identification card or other means of identifying them as Members and covered under self-funded or insured health benefits plans to which **Provider** has agreed to participate as set forth in the product participation list attachment.

2.2 **Provider** further agrees to provide Health Care Services to individuals covered under other third party payors' (hereinafter referred to as "**Payor**" or "**Payors**") health benefits contracts (hereinafter referred to as "**Plan**" or "**Plans**") and agrees to comply with such Payors' policies and procedures. For Covered Services rendered to such individuals, **Provider** acknowledges and agrees that all rights and responsibilities arising with respect to benefits to such individuals shall be subject to the terms of the Payor Plan covering such individuals. Individuals covered under such Plans will have an identification card as a means of identifying the Payor Plan which provides coverage. Such identification cards will display a **Humana** logo and/or name.

2.3 For Covered Services provided to those individuals identified in Section 2.2 above, **Provider** will accept payments for Covered Services from Plans in accordance with the terms and conditions of this Agreement and the rates set forth in the Payment Attachment applicable to the type of Plan. **Provider** agrees that in no event, including, but not limited to, nonpayment by Payor, or Payor's insolvency, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against **Humana** for services provided by **Provider** to such Plans' Members. This provision shall not prohibit collection by **Provider** from Plans' Members for non-covered services and/or Member cost share amounts in accordance with the terms of the applicable Member Plan. Payors Plans will provide appropriate steerage mechanisms including benefit designs and/or provider directory and web site listings to ensure their covered individuals have incentives to utilize **Provider's** services. All obligations of **Provider** under this Agreement with respect to **Humana's** Members shall equally apply to the individuals identified in Section 2.2 above.

## THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement, the parties have not created and do not intend to create by this Agreement any rights in other parties as third party beneficiaries of this Agreement, including, without limitation, Members.

## SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of **Provider** and **Provider's** employees, subcontractors and independent contractors as health care providers (hereinafter referred to as "**Participating Providers**") providing Health Care Services; and (ii) **Provider's** provision of medical or related Health Care Services (hereinafter referred to as "**Provider Services**") to Members. All terms and conditions of this Agreement which are applicable to "**Provider**" are equally applicable to each Participating Provider, unless the context requires otherwise.

4.2 **Provider** acknowledges and agrees that its Participating Providers will abide by the terms and conditions of this Agreement. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between **Provider** and Members regarding the Members' medical conditions or treatment options, and **Provider** acknowledges that all patient care and related decisions are the sole responsibility of **Provider** and **Humana** does not dictate or control clinical decisions with respect to the medical care or treatment of Members. **Provider** agrees to provide **Humana**, upon request, with copies of orders from Member's attending physician.

4.3 **Provider** acknowledges and agrees that with respect to self-funded groups, unless otherwise provided herein, **Humana's** responsibilities hereunder are limited to provider network administration and/or claims processing.

## ACQUISITIONS

5.1 This Section 5.1 applies to any **Provider** acquisition through any means including, but not limited to, asset or stock purchase, merger, or consolidation (collectively, "**Acquisition**") of an ownership interest in a facility or other provider of whatever type or construction including, but not limited to, a (i) hospital, (ii) free standing ambulatory surgery center, (iii) radiology center, (iv) sleep center; or (v) physician, physician group, Independent Practice Association or Physician Hospital Organization (collectively, "**Entity**"). In the event of **Provider's** Acquisition of an Entity and such Entity has an agreement in effect with **Humana** for the provision of Health Care Services, then such Entity shall not become a participating provider with **Humana** under this Agreement but, rather, the existing separate agreement between **Humana** and such Entity will control for its duration. Furthermore, **Provider** shall not exercise any termination or nonrenewal right which may exist in the agreement between **Humana** and such Entity for a period of twelve (12) months subsequent to the effective date **Provider** acquires its ownership interest in such Entity.

5.2 In the event **Provider's** ownership, separate existence or entity construction (e.g., corporation, limited liability company, etc.) is altered or affected in any way as a result of acquisition, merger, consolidation or through any other means whatsoever (including, but not limited to, being merged into an affiliated entity), then this Agreement shall continue to control with respect to **Provider's** provision of Health Care Services to **Humana's** Members notwithstanding any contrary outcome which may otherwise be allowed or required by law. Furthermore, **Provider** agrees that it shall not exercise any termination or nonrenewal right which may otherwise exist in this Agreement for a period of twelve (12) months subsequent to the effective date of such transaction event.

## TERM AND TERMINATION

6.1 This term of this Agreement shall commence on the date **Humana** inserts in this Agreement (the "**Effective Date**"). **Humana** has full authority to determine the Effective Date according to **Humana's** processing and/or credentialing requirements. The Initial Term of this Agreement shall be for three (3) years ("Initial Term"). After the Initial Term, this Agreement shall automatically renew for subsequent one (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.

6.2 Notwithstanding anything to the contrary herein, after the Initial Term, either party may terminate this Agreement without cause at any time following the initial term of this Agreement by providing to the other party ninety (90) days prior written notice of termination.

6.3 **Humana** may terminate this Agreement immediately upon written notice to **Provider**, stating the cause for such termination, in the event: (i) **Provider's** or any Participating Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or brings **Humana** or its health care networks into disrepute; (ii) **Provider** or any Participating Provider fails to meet **Humana's** credentialing or re-credentialing criteria; (iii) **Provider** or any Participating Provider is excluded from participation in any federal health care program; (iv) **Provider** voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings or engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors; or (v) **Humana** loses its authority to do business in total or as to any limited segment of business, but then only as to that segment.

6.4 In the event of a breach of this Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party, which notice shall specify in detail the nature of the alleged breach; provided, however, that if the alleged breach is susceptible to cure, the breaching party shall have thirty (30) days from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination shall be void of and of no effect. If the breach is not cured within the thirty (30) day period, then the date of termination shall be that date set forth in the notice of termination. Notwithstanding the foregoing, any breach related to credentialing or re-credentialing, quality assurance issues or alleged breach regarding termination by **Humana** in the event that **Humana** determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring **Humana** or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination upon written notice to **Provider**.

6.5 **Provider** agrees that the notice of termination or expiration of this Agreement shall not relieve **Provider** of its obligation to provide or arrange for the provision of Provider Services through the effective date of termination or expiration of this Agreement.

6.6 **Provider** agrees that **Humana** may terminate **Provider** or an individual Participating Provider's participation from one or more line(s) of business and/or provider network(s) covered by this Agreement by providing ninety (90) days prior written notice to **Provider**. In such event, the affected **Provider** or Participating Provider(s) shall remain participating with respect to all other line(s) of business, if any, and/or provider network(s) covered by this Agreement.

## POLICIES AND PROCEDURES

7.1 **Provider** agrees to comply with **Humana's** quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by **Humana** from time to time and, in addition, those policies and procedures which are set forth in **Humana's** Provider Manual for Physicians, Hospitals and Other Health Care Providers, or its successor (hereinafter referred to as the "**Manual**"), and bulletins or other written materials that may be promulgated by **Humana** from time to time to supplement the Manual. The Manual and updated policies and procedures may be issued and distributed by **Humana** in electronic format. Paper copies may be obtained by **Provider** upon written request. Revisions to such policies and procedures shall become binding upon **Provider** ninety (90) days after such notice to **Provider** by mail or electronic means, or such other period of time as necessary for **Humana** to comply with any statutory, regulatory and/or accreditation requirements.

7.2 **Humana** shall maintain an authorization procedure for **Provider** to verify coverage of Members under a **Humana** health benefits contract.

7.3 Notwithstanding anything to the contrary in this Agreement or in the Member's health benefits contract, **Provider** shall obtain authorization from **Humana** prior to the provision of those services for which **Humana** requires prior authorization. Prior to rendering any non-emergent service, **Provider** is responsible for determining if such service requires prior authorization by reviewing **Humana's** prior authorization requirements posted on http://www.humana.com/providers/ (or any subsequent location as may be specified in the Manual or otherwise by written notice) or by contacting **Humana's** customer service phone number, as indicated on Member's identification card. **Provider's** failure to obtain required prior authorization may result in a fifty percent (50%) reduction of the amount, if any, that would otherwise be due under this Agreement for the service. With respect to the amount by which the payment was reduced, **Provider** shall not under any circumstance bill, charge, seek, receive and/or retain payment from Member. Further, in the event the reduction described herein is effected, **Provider** shall refund any excess Copayment amounts collected from Member.

## CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE

8.1 Participation under this Agreement by **Provider** and Participating Providers is subject to the satisfaction of all applicable credentialing and re-credentialing standards established by **Humana**. **Provider** shall provide **Humana**, or its designee, information necessary to ensure compliance with such standards at no cost to **Humana** or its designee. **Provider** agrees to use electronic credentialing and recredentialing processes when administratively feasible.

8.2 **Provider** shall maintain, at no expense to **Humana**, policies of comprehensive general liability, professional liability, and workers' compensation coverage, insuring **Provider** and **Provider's** employees and agents against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the provision of Health Care Services contemplated by this Agreement and/or the maintenance of **Provider's** facilities and equipment. Upon request, **Provider** shall provide **Humana** with evidence of said coverage. **Provider** shall within ten (10) business days following service upon **Provider**, or such other period of time as may be required by any applicable law, rule or regulation, notify **Humana** in writing of any Member lawsuit alleging malpractice involving a Member.

## PROVISION OF MEDICAL SERVICES

9.1 **Provider** shall provide Members all available Health Care Services within the normal scope of and in accordance with **Provider's** licenses, certifications and privileges to provide certain services as delineated by Humana. **Provider** agrees to comply with all requests for information related to Humana determination of **Provider's** privileging status. **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of Health Care Services for which privileges have not been granted to **Provider** by **Humana**.

9.2 **Provider** shall maintain all medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter referred to as "**Equipment**") in acceptable working order and condition and in accordance with the Equipment manufacturer's recommendations for scheduled service and maintenance. Such Equipment shall be located in areas that promote patient and employee safety. **Provider** shall provide **Humana** or its agents with access to such Equipment for inspection and an opportunity to review all records reflecting Equipment maintenance and service history. Such Equipment shall only be operated by qualified technicians with appropriate training and required licenses and certifications.

9.3 Equipment owned and/or operated by **Provider** shall comply with all standards for use of such Equipment and technician qualifications established by **Humana**. **Provider** agrees to comply with all requests for information related to Equipment and **Provider's** and/or **Provider's** staff, qualifications for use of same. In the event: (i) **Provider's** Equipment fails to meet **Humana's** standards; or (ii) **Provider** declines to comply with **Humana's** standards for use of Equipment, **Provider** agrees that it will not use such Equipment while providing Health Care Services to Members and shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts for Health Care Services with respect to such Equipment.

## STANDARDS OF PROFESSIONAL PRACTICE

10.1 Health Care Services shall be made available to Members without differentiation or discrimination on the basis of type of health benefits plan, source of payment, employment status, socioeconomic status, sex, sexual preference, age, race, ethnicity, religion, national origin, health status, disability, military service or veterans' status. **Provider** shall provide Health Care Services to Members in the same manner as provided to its other patients and in accordance with prevailing practices and standards of care.

## QUALITY AND UTILIZATION REVIEW DATA REQUESTED BY HUMANA

11.1 **Provider** agrees to participate in **Humana's** utilization review program, whether performed internally or by an external vendor of **Humana's** choosing, and to provide data requested by **Humana** to conduct quality and utilization review activities concerning **Humana** Members.

11.2 **Provider** agrees to obtain from Members authorization for **Humana's** review personnel to have access to Members during their term of treatment and to Members' medical records, and pursuant to such authorization, provide **Humana's** review personnel such access. **Provider** further agrees to furnish **Humana's** review personnel access to **Provider** and **Provider's** personnel during the term of a Member's treatment.

## MEDICAL RECORDS

12.1 **Provider** shall prepare, maintain and retain as confidential the medical records of all Members receiving Health Care Services, and Members' other personally identifiable health information received from **Humana**, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which **Provider** is subject, and in accordance with accepted medical practice. **Provider** shall obtain authorization of Members permitting **Humana** or its designee, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any medical record of Member related to Health Care Services provided by **Provider** pursuant to applicable state and federal laws. Copies of such records for the purpose of claims processing shall be made and provided by **Provider** at no cost to **Humana** or the Member.

12.2 Upon request from **Humana** or a Member, **Provider** shall transfer a complete copy of the medical records of any Member transferred to another physician and/or facility for any reason, including termination or expiration of this Agreement. The copy and transfer of medical records shall be made at no cost to **Humana** or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) business days, except in cases of emergency where the transfer shall be immediate. **Provider** agrees that such timely transfer of medical records is necessary to provide for the continuity of care for Members. **Provider** agrees to pay court costs and/or legal fees incurred by Humana or the Member to enforce the terms of this provision.

12.3 **Provider** and **Humana** agree, and **Humana** will require its designee to agree, to maintain the confidentiality of information maintained in the medical records of Members, and information obtained from **Humana** through the verification of Member eligibility, as required by law. This **Section 12.3** shall survive any expiration or termination of this Agreement, regardless of the cause.

## GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION

13.1 **Grievance and Appeals; Internal Administrative Review**. **Provider** shall cooperate and participate with **Humana** in grievance and appeals procedures to resolve disputes that may arise between **Humana** and its Members. **Provider** and **Humana** further agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal procedures prior to submitting any matters to binding arbitration.

13.2 **Agreement to Arbitrate**. The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration under the Healthcare Payor Provider Arbitration Rules of the American Arbitration Association ("**AAA**"), including disputes concerning the scope, validity or applicability of this agreement to arbitrate ("**Arbitration Agreement**"). The parties agree that this Arbitration Agreement is subject to, and shall be interpreted in

accordance with, the Federal Arbitration Act, 9 U.S.C. §§ 1-16. No claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law. Without limiting the foregoing, this Arbitration Agreement requires arbitration of disputes involving antitrust, racketeering and similar claims. This Arbitration Agreement supersedes any prior arbitration agreement between the parties. The parties agree to arbitrate disputes arising from the parties' business relationship prior to the effective date of the Agreement under the terms of this arbitration provision. This Arbitration Agreement, however, does not revive any claims that were barred by the terms of prior contracts, by applicable statutes of limitations or otherwise.

13.3. **Arbitration Process**. The arbitration shall be conducted by one neutral arbitrator selected by the parties from the AAA National Healthcare Panel of arbitrators. The arbitrator shall have prior professional, business or academic experience in health care, managed care or health insurance matters. In the event of an arbitration of antitrust claims, the arbitrator shall have prior professional, business or academic experience in antitrust matters. The arbitration shall be conducted in a location selected by mutual agreement or, failing agreement, at a location selected by the AAA that is no more than fifty (50) miles from **Provider's** place of business. The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings, except to the extent the applicable substantive law specifically provides otherwise.

13.4 **Joinder; Class Litigation**. Any arbitration under this Arbitration Agreement shall be solely between **Humana** and **Provider**, shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

13.5 **Expense of Compelling Arbitration**. If either party commences a judicial proceeding asserting claims subject to this Arbitration Agreement or refuses to participate in an arbitration commenced by the other party, and the other party obtains a judicial order compelling arbitration of such claims, the party that commenced the judicial proceeding or refused to participate in an arbitration in violation of this Arbitration Agreement shall pay the other party's costs incurred in obtaining an order compelling arbitration, including the other party's reasonable attorneys' fees.

13.6 **Judgment on the Decision and Award**. Judgment upon the decision and award rendered by an arbitrator under this Arbitration Agreement may be entered in any court having jurisdiction thereof.

## USE OF PROVIDER'S NAME

14.1 **Humana** may include the following information in any and all marketing and administrative materials published or distributed in any medium: **Provider's** name, the names of all Participating Providers, **Provider's** and Participating Providers' telephone numbers, addresses, available services, and **Provider's** Internet web-site address. **Humana** will provide **Provider** with access to such information or copies of such administrative or marketing materials upon request.

14.2 **Provider** may advertise or utilize marketing materials, logos, trade names, service marks, or other materials created or owned by **Humana** after obtaining **Humana's** written consent. **Provider** shall not acquire any right or title in or to such materials as a result of such permissive use.

14.3 **Provider** agrees to allow **Humana** to distribute a public announcement of **Provider's** affiliation with **Humana**.

## PAYMENT

15.1 **Provider** shall accept payment from **Humana** for those Health Care Services provided to Members for which benefits are payable under a Member's health benefits contract (herein referred to as "**Covered Services**") provided to Member in accordance with the reimbursement terms in the Payment Attachment. **Provider** shall collect directly from Member any co-payment, coinsurance, or other Member cost share amounts (hereinafter referred to as "**Copayments**") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments. Payments made in accordance with the Payment Attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be

accepted by **Provider** as payment in full from **Humana** for all Covered Services. This provision shall not prohibit collection by **Provider** from Member for any services not covered under the terms of the applicable Member health benefits contract. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

15.2 **Provider** agrees that payment may not be made by **Humana** for Health Care Services rendered to Members which are determined by **Humana** not to be Medically Necessary. "**Medically Necessary**" (or "**Medical Necessity**"), unless otherwise defined in the applicable Member health benefits contract, means services or supplies provided by a licensed, certified or approved, as applicable, hospital, physician or other health care provider to identify or treat a condition, disease, ailment, sickness or bodily injury and which, in the opinion of **Humana**, are: (i) consistent with the symptoms, diagnosis and treatment of the condition, disease, ailment, sickness or bodily injury; (ii) appropriate with regard to standards of accepted medical practice; (iii) not primarily for the convenience of the patient or the hospital, physician, or other health care provider; (iv) the most appropriate and cost-effective supply, setting, or level of service which safely can be provided to the patient; and (v) substantiated by records and documentation maintained by the provider of services. When applied to an inpatient, it further means that the patient's symptoms or condition requires that the services or the supplies cannot be provided safely to the patient as an outpatient. Notwithstanding anything to the contrary in this Agreement, **Provider** agrees that in the event of a denial of payment for Health Care Services rendered to Members determined not to be Medically Necessary by **Humana**, that **Provider** shall not bill, charge, seek payment or have any recourse against Member for such services. Notwithstanding the immediately preceding sentence, **Provider** may bill the Member for services determined not to be Medically Necessary if **Provider** provides the Member with advance written notice that: (a) identifies the proposed services, (b) informs the Member that such services may be deemed by **Humana** to be not Medically Necessary, and (c) provides an estimate of the cost to the Member for such services and the Member agrees in writing in advance of receiving such services to assume financial responsibility for such services.

15.3 **Provider** agrees that **Humana** may recover overpayments made to **Provider** by **Humana** by offsetting such amounts from later payments to **Provider**, including, without limitation, making retroactive adjustments to payments to **Provider** for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. **Humana** shall provide **Provider** thirty (30) days advance written notice of **Humana's** intent to offset such amounts prior to deduction of any monies due. If **Provider** does not refund said monies or request review of the overpayments described in the notice within thirty (30) days following receipt of notice from **Humana**, **Humana** may without further notice to **Provider** deduct such amounts from later payments to **Provider**. **Humana** may make retroactive adjustments to payments for a period not to exceed eighteen (18) months from original date of payment or such other period as may be required or allowed by applicable law.

15.4 In the event **Humana** has access to **Provider's**, or a Participating Provider's, services through one or more other agreements or arrangements in addition to this Agreement, **Humana** will determine under which agreement payment for Covered Services will be made.

15.5 Nothing contained in this Agreement is intended by **Humana** to be a financial incentive or payment that directly or indirectly acts as an inducement for **Provider** to limit Medically Necessary services.

15.6 Notwithstanding any other reimbursement terms specified in this Agreement, for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent) the reimbursement for which under this Agreement is determined in whole or in part by a Medicare reimbursement methodology, the final payment amount to **Provider** as determined under this Agreement shall be reduced in the same manner as the reduction in the final payment amount that CMS is applying to provider payments in Medicare Parts A and/or B pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011, or any successor legislation ("**Sequestration**"). This provision is effective April 1, 2013 and shall apply for the duration of the time in which Sequestration reductions apply to provider payments under Medicare Parts A and/or B.

**SUBMISSION OF CLAIMS**

16.1 **Provider** shall submit all claims and encounters to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") compliant 837 electronic format, or a UB-04 and/or a CMS 1500 paper format (in accordance with industry standard), or their successors. Claims and encounters will utilize HIPAA compliant Code Sets for all coded values. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the Health Care Services reported on the claim. Claims shall be submitted within ninety (90) days from the date of service or within the time specified by applicable state law. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after the later of ninety (90) days from the date of service, or the time specified by applicable state law. **Provider** acknowledges and agrees that at no time shall Members be responsible for any payments to **Provider** except for applicable Copayments and non-covered services provided to such Members.

16.2 **Humana** will process **Provider** claims which are accurate and complete in accordance with **Humana's** normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the Health Care Services provided to Members. These automated systems may result in an adjustment of the payment to the **Provider** for the Health Care Services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. **Provider** may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to **Humana**. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may **Provider** bill a Member for any amount adjusted in payment. In no event may **Provider** bill a Member for any amount adjusted in payment.

16.3 Unless applicable law mandates submission may be in paper format, **Provider** shall submit all claims, encounters, and clinical data to **Humana** by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by **Humana**. **Provider** acknowledges that **Humana** may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate. **Provider** shall notify **Humana** when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to **Humana** upon request. Unless applicable law mandates submission may be in paper format, **Provider** shall submit to **Humana** all **Humana** required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

## COORDINATION OF BENEFITS

17.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between the primary Payor's allowed amount and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement; provided, however, if Medicare is the primary payer, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("**CMS**") Office of Inspector General ("**OIG**") guidance, pay **Provider** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

## NO LIABILITY TO MEMBER FOR PAYMENT

18.1 **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Health Care Services provided by **Provider**. This provision shall not prohibit collection by

**Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract.

18.2 **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

18.3 Any modification to this **Section 18** shall not become effective unless approved by the Commissioner of Insurance, in the event such approval is required by applicable state law or regulation, or such changes are deemed approved in accordance with state law or regulation.

## ACCESS TO INFORMATION

19.1 **Provider** agrees that **Humana** or its designee, or any state or federal regulatory agency as required by law, shall have reasonable access and an opportunity to examine **Provider's** financial and administrative records as they relate to Health Care Services provided to Members during normal business hours, on at least seventy-two (72) hours advance notice, or such shorter notice as may be imposed on **Humana** by a federal or state regulatory agency or accreditation organization.

## NEW PRODUCT INTRODUCTION AND NETWORK SELECTION

20.1 From time to time during the term of this Agreement, **Humana** may develop or implement new products. Should **Humana** offer participation in any such new product to **Provider**, **Provider** shall be provided with ninety (90) days' written notice prior to the implementation of such new product. If **Provider** does not object in writing to its participation in such new product within such ninety (90) day notice period, **Provider** shall be deemed to have accepted participation in the new product. In the event **Provider** objects to its participation in a new product, the parties shall confer in good faith to reach agreement on the terms of **Provider's** participation. If agreement on such new product cannot be reached, such new product shall not apply to this Agreement.

20.2 **Humana** may in its discretion, establish, develop, manage and market provider networks in which **Provider** may not be selected to participate. In addition, **Provider** agrees to participate as a network provider in health benefits plans that **Humana** may establish, develop and/or manage that have varying Member Copayment obligations on services provided by **Humana** participating providers, including **Provider**.

## ASSIGNMENT AND DELEGATION

21.1 The assignment by **Provider** of this Agreement or any interest hereunder shall require notice to and the written consent of **Humana**. As used in this paragraph, the term "assignment" shall also include a change of control in **Provider** by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in **Provider**. Any attempt by **Provider** to assign this Agreement or any interest hereunder without complying with the terms of this paragraph shall be void and of no effect, and **Humana**, at its option, may elect to terminate this Agreement upon thirty (30) days written notice to **Provider**, without any further liability or obligation to **Provider**. **Humana** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **Humana**, or to any affiliate of **Humana**, provided that the assignee agrees to assume **Humana's** obligations under this Agreement. Upon notice of an assignment by **Humana**, **Provider** may terminate this Agreement upon thirty (30) days written notice to **Humana**.

## COMPLIANCE WITH REGULATORY REQUIREMENTS

22.1 **Provider** acknowledges, understands and agrees that this Agreement may be subject to the review and approval of state regulatory agencies with regulatory authority over the subject matter of this Agreement. Any modification of this Agreement requested by such agencies or required by applicable law or regulations shall be incorporated herein as provided in **Section 24.10**, of this Agreement.

22.2 **Provider** and **Humana** agree to be bound by and comply with the provisions of all applicable state and/or federal laws, rules and regulations. The alleged failure by either party to comply with applicable state and federal laws or regulations shall not be construed as allowing either party a private right of action against the other in any court, administrative or arbitration proceeding in matters in which such right is not recognized or authorized by such law or regulation. If **Provider** violates any of the provisions of applicable state and/or federal laws, rules and regulations, or commits any act or engages in conduct for which **Provider's** or other Participating Providers' professional license, certification, registration or accreditation is revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which **Provider** or Participating Providers are licensed or certified, **Humana** may immediately terminate this Agreement or any individual Participating Provider.

22.3 **Provider** shall procure and maintain for the term of this Agreement such accreditation, certification, licensure and/or registration as is required under all applicable state and federal laws and regulations, and further shall ensure appropriate accreditation, certification, licensure and/or registration of all of its Participating Providers required to be so accredited, certified, licensed and/or registered, in accordance with all applicable state and federal laws, rules and regulations. **Provider** shall notify **Humana** immediately of any suspensions, revocations, restrictions or any other changes in its or its Participating Providers' accreditation, certification, licensure or registration status.

## DISPUTE RESOLUTION/LIMITATIONS ON PROCEEDINGS

23.1 **Provider** and **Humana** agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal mechanisms prior to submitting any matters to binding arbitration.

23.2 **Provider** may contest the amount of the payment, denial or nonpayment of a claim only within a period of eighteen (18) months following the date such claim was paid, denied or not paid by the required date by **Humana**. In order to contest such payments, **Provider** shall provide to **Humana**, at a minimum, in a clear and acceptable written format, the following information: Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of the services, charge amount, payment amount, the allegedly correct payment amount, difference between the amount paid and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. **Humana** will review such contestation(s) and respond to **Provider** within sixty (60) days of the date of receipt by **Humana** of such contestation.

## MISCELLANEOUS PROVISIONS

24.1 **SEVERABILITY**. If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

24.2 **GOVERNING LAW**. This Agreement shall be governed by and construed in accordance with the applicable laws of the State of Kentucky. The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. Such state law provisions, if any, are set forth in the state law coordinating provisions attachment. Such federal law provisions, if any, are set forth in the Medicare Advantage provisions attachment. The parties agree to comply with any and all such provisions and in the event of a conflict between the provisions in the state law coordinating provisions attachment and/or the Medicare Advantage provisions attachment and any other provisions in this Agreement, the provisions in those attachments, as applicable, shall control. In the event that state and/or federal laws, rules or regulations enacted after the Effective Date expressly require specific language be included in this Agreement, such provisions are hereby incorporated by reference without further notice by or action of the parties and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

24.3 **WAIVER**. The waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent or continuing breach of the same provision. In addition, the waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy at any subsequent time if a condition of default continues or recurs.

24.4 **NOTICES**. Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to **Section 7**, required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been given: (i) on the date of personal delivery; or (ii) provided such notice, request, demand or other communication is received by the party to which it is addressed in the ordinary course of delivery: (a) on the third day following deposit in the United States mail, postage prepaid, or by certified mail, return receipt requested; (b) on the date of transmission by facsimile transmission; or (c) on the date following delivery to a nationally recognized overnight courier service, each addressed to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith. **Humana** may also provide such notices to **Provider** by electronic means to the e-mail address of **Provider** set forth on the Cover Sheet to this Agreement or to other e-mail addresses **Provider** provides to **Humana** by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term "**Provider**" or "**Humana**" shall constitute notice to all parties included in the respective terms.

24.5 **CONFIDENTIALITY**. **Provider** agrees that the terms of this Agreement and information regarding any dispute arising out of this Agreement are confidential, and agrees not to disclose the terms of this Agreement nor information regarding any dispute arising out of this Agreement to any third party without the express written consent of **Humana**, except pursuant to a valid court order, or when disclosure is required by a governmental agency. Notwithstanding anything to the contrary herein, the parties acknowledge and agree that **Provider** may discuss the payment methodology included herein with Members requesting such information.

24.6 **COUNTERPARTS, HEADINGS AND CONSTRUCTION**. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together constitute one and the same instrument. The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. Unless the context otherwise requires, when used in this Agreement, the singular shall include the plural, the plural shall include the singular, and all nouns, pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, as the identity of the person or persons may require. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the provision.

24.7 **INCORPORATION OF ATTACHMENTS**. All attachments attached hereto are incorporated herein by reference.

24.8 **FORCE MAJEURE**. Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party's failure to perform under the terms of this Agreement is due to an act of God, riot, war or natural disaster.

24.9 **ENTIRE AGREEMENT**. This Agreement, including the attachments, addenda and amendments hereto and the documents incorporated herein, constitutes the entire agreement between **Humana** and **Provider** with respect to the subject matter hereof, and it supersedes any prior or contemporaneous agreements, oral or written, between **Humana** and **Provider**.

24.10 **MODIFICATION OF AGREEMENT**. This Agreement may be amended in writing as mutually agreed upon by **Provider** and **Humana**. In addition, **Humana** may amend this Agreement upon ninety (90) days' written notice to **Provider**. Failure of **Provider** to object in writing to such amendment during the ninety (90) day notice period shall constitute acceptance of such amendment by **Provider**.

Each party to this Agreement represents that it has full power and authority to enter into this Agreement and the person signing below on behalf of either party represents that they have been duly authorized to enter into this Agreement on behalf of the party they represent. This Agreement is effective as of the Effective Date of _____.

**PROVIDER/AUTHORIZED SIGNATORY**

Legal Entity: _____

Provider DBA Name: _____

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Tax ID: _____

**HUMANA**

Signature: _____

Printed Name: _____

Title: _____

Date: _____

**Address For Notice:**

**PROVIDER:**

**HUMANA:**

Copy to:
Humana Inc.
P.O. Box 1438
Louisville, Kentucky 40201-1438
Attn: Law Department

**PRODUCT PARTICIPATION LIST**
**ATTACHMENT**

**Provider** agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by **Humana**.

**Health Benefits Plan** **(Check only those which apply)**

Commercial PPO Plans

Commercial HMO Plans

Commercial POS Plans

Commercial EPO Plans

Medicare PPO Plans

Medicare POS Plans

Medicare Network PFFS Plans

Medicare HMO Plans

Kentucky Medicaid HMO

Traditional Plans

**PROVIDER LOCATIONS ATTACHMENT**

(To be provided by **Provider** prior to execution of this Agreement.)

The following is a list of **Provider's** locations, including address, telephone and fax numbers, tax identification number, National Provider Identifier ("**NPI**"), contact person, office hours, specialty services available for each service location included in this Agreement and other **Provider** personnel who will be providing services to **Humana** Members under this Agreement. **Provider** shall provide **Humana** with no less than sixty (60) days prior written notice of any addition, change or closing of a location. **Provider** will provide updates of this listing to **Humana** on a quarterly basis.

# STATE LAW COORDINATING PROVISIONS ATTACHMENT

## KENTUCKY

**Humana** and **Provider** agree that the following provisions are incorporated into the Agreement solely to the extent specifically required to ensure compliance with applicable Kentucky laws, rules and/or regulations. To the extent this Agreement covers any Medicare Advantage line(s) of business, the parties further agree that none of the provisions of this attachment apply to same.

**1.** To the extent that **Humana** requires submission of health claim attachments to claims, containing medical information related to the diagnosis, the treatment, or services rendered to the Member before the claim will be paid, **Humana** shall identify the specific required health claim attachments in its provider manual or other document that sets forth the procedure for filing claims. **Humana** shall give at least sixty (60) days advance written notice of modifications to its provider manual or other document that materially change the type or content of the health claim attachments required to be submitted.

**2.** Notwithstanding anything to the contrary in the Agreement, **Provider** is not required to appeal a payment error by **Humana**. As used in this Agreement, a "payment error" occurs when a claim has not been paid according to the contracted rate. **Humana** will correct payment errors and pay any underpayment within thirty (30) days of receiving documentation from **Provider** verifying the error. **Humana**, however, shall not be required to correct payment errors if **Provider's** request for correction is received by **Humana** more than two (2) years after the date **Provider** received payment.

**3.** **Provider** hereby agrees that in the event **Provider** enters into any subcontract(s) with other health care provider(s) for the provision of services to Members under the Agreement where such subcontracted provider will bill **Humana** or the Member directly for such services, such subcontracts shall meet the requirements of all applicable state and/or federal laws, rules and/or regulations. The parties agree that a sample copy of any such subcontract(s) shall be provided to **Humana** for filing with the Commissioner of the Kentucky Department of Insurance in accordance with applicable laws, rules and/or regulations.

**4.** **Provider** agrees in the event of termination or expiration of the Agreement for any reason, other than for reasons of quality of care or fraud, **Provider** shall continue to provide services to Members under the terms and conditions of the Agreement until the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time period is greater, and in the case of a pregnant Member in the fourth or later month of pregnancy, services shall be provided until the end of the post-partum period. The parties agree this continuity of care provision shall survive any termination or expiration of the Agreement.

**5.** Within thirty (30) days of receipt of **Provider's** written request for fees for specific code(s), **Humana** shall provide **Provider** with the fee(s) which are payable with respect to such code(s) under the terms and conditions of the Agreement.

**6.** Notwithstanding anything to the contrary in **Section 6.2**, any termination of this Agreement without cause shall not be applicable to any Health Care Services rendered in the Commonwealth of Kentucky.

**7.** The third sentence of **Section 13.2** is deleted and replaced with the following:

Other than a claim brought under Kentucky state law which provides for a resolution of the dispute through regulatory channels, no claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law.

**8.** The first sentence of **Section 20.2** is deleted and replaced with the following:

**Humana** may, in its discretion, develop, manage and market provider networks in which **Provider** may not be eligible to participate based upon **Humana's** terms and conditions for participation in such networks.

**9.** The parties agree that nothing contained in this Agreement shall be construed to be a requirement that, as a condition of participation in a health benefit plan of **Humana**, that **Provider** participate in any of **Humana's** other health benefit plans.

## MEDICARE ADVANTAGE PROVISIONS ATTACHMENT

The following additional provisions ("Medicare Advantage Provisions") relate specifically to Medicare Advantage products and plans and are hereby incorporated by reference into the Agreement.

**a)** **Provider** agrees to: (i) abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state and/or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

**b)** **Humana** and **Provider** agree that **Humana** will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt.

**c)** **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Provider** for which payment is the legal obligation of **Humana**. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of this Agreement and the applicable Member health benefits contract. **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

**d)** **Provider's** performance of services under the Agreement shall be consistent and in compliance with **Humana's** contractual obligations under its Medicare Advantage contract(s). **Provider** agrees to cooperate with and assist **Humana** in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist **Humana** in complying with corrective action plans necessary for **Humana** to comply with such rules and regulations.

**e)** **Provider** agrees that nothing in the Agreement shall be construed as relieving **Humana** of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

**f)** **Provider** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, the rights of **Humana** and applicable federal and state regulatory agencies including, but not limited to, HHS, the Comptroller General or their designees, to evaluate, inspect and audit **Provider's** operations, books, records, and other documentation and pertinent information related to **Provider's** obligations under the Agreement, as well as all other state and federal laws, rules and regulations applicable to individuals and entities receiving federal funds. **Provider** further agrees that such rights to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between **Humana** and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

**g)** **Provider** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to **Provider's** obligations under the Agreement for a period of not less than ten (10) years from: (i) each successive December 31; or (ii) the end of the contract period between **Humana** and CMS; or (iii) from the date of completion of any audit, whichever is later.

**h)** **Provider** agrees in the event certain identified activity(ies) have been delegated to **Provider** under the Agreement, any sub-delegation of the noted activity(ies) by **Provider** requires the prior written approval of

**Humana**. Notwithstanding anything to the contrary in the Agreement, **Humana** will monitor **Provider's** performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event **Humana** and/or CMS determines, in their discretion, that **Provider** is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that **Humana** has delegated all or any part of the claims payment process to **Provider** under the Agreement, **Provider** shall comply with all prompt payment requirements to which **Humana** is subject. **Humana** agrees that it shall review the credentials of **Provider** or, if **Humana** has delegated the credentialing process to **Provider**, **Humana** shall review and approve **Provider's** credentialing process and audit it on an ongoing basis.

**i)** **Provider** agrees to comply with **Humana's** policies and procedures and complete general compliance training and fraud, waste, and abuse training as required by CMS.

**j)** **Provider** agrees to maintain full participation status in the federal Medicare program. This also includes all of **Provider's** employees, subcontractors, and/or independent contractors who will provide services, including, without limitation, health care, utilization review, medical social work, and/or administrative services under the Agreement.

**k)** **Provider** agrees that payment from **Humana** for services rendered to **Humana's** Medicare Advantage Members is derived, in whole or in part, from federal funds received by **Humana** from CMS.

**l)** **Provider** agrees to disclose to **Humana**, upon request and within thirty (30) days or such lesser period of time required for **Humana** to comply with all applicable state and/or federal laws, all of the terms and conditions of any payment arrangement that constitutes a "physician incentive plan" as defined by CMS and/or any federal law or regulation. Such disclosure should identify, at a minimum, whether services not furnished by the physician/provider are included, the type of incentive plan including the amount, identified as a percentage, of any withhold or bonus, the amount and type of any stop-loss coverage provided for or required of the physician/provider, and the patient panel size broken down by total group or individual physician/provider panel size, and by the type of insurance coverage (i.e., Commercial HMO, Medicare Advantage HMO, Medicare PPO, and Medicaid HMO).

**m)** **Provider** agrees that in the event of **Humana's** insolvency or termination of **Humana's** contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

**n)** **Provider** agrees to provide or arrange for continued treatment, including, but not limited to, medication therapy, to Medicare Advantage Members upon expiration or termination of the Agreement. In accordance with all applicable state and federal laws, rules and/or regulations, treatment must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Medicare Advantage Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Medicare Advantage Member; and (ii) until the date of discharge for Medicare Advantage Members hospitalized on the effective date of termination or expiration of the Agreement. **Provider** agrees to accept as payment in full from **Humana** for Covered Services rendered to **Humana's** Medicare Advantage Members, the rates set forth in the Payment Attachment(s) which are applicable to such Member.

**o)** **Provider** agrees to cooperate with the activities and/or requests of any independent quality review and improvement organization utilized by and/or under contract with **Humana** as related to the provision of services to Medicare Advantage Members.

**p)** **Provider** agrees to cooperate with **Humana's** health risk assessment program.

**q)** **Provider** agrees to provide to **Humana** accurate and complete information regarding the provision of Covered Services by **Provider** to Members ("**Data**") on a complete CMS 1500 or UB-04 form, or their respective successor forms as may be required by CMS, or such other form as may be required by law when submitting claims and encounters in an electronic format, or such other format as is mutually agreed upon by both parties. The Data shall be provided to **Humana** on or before the last day of each month for encounters occurring in the immediately preceding month, or such lesser period of time as may be required in the Agreement, or as is otherwise agreed upon by the parties in writing. The submission of the Data to

**Humana** and/or CMS shall include a certification from **Provider** that the Data is accurate, complete and truthful. In the event the Data is not submitted to **Humana** by the date and in the form specified above, **Humana** may, in its sole option, withhold payment otherwise required to be made under the terms of the Agreement until the Data is submitted to **Humana**.

**r)** **Provider** agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any **Humana** Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("**QMB**") by CMS.

**s)** **Provider** agrees to require its employed and contracted health care providers and health care professionals providing services under the Agreement to comply with the terms and conditions of the Agreement. **Provider** must maintain written agreements with any contracted health care providers and health care professionals, as applicable, that include terms and conditions that comply with the Medicare Advantage Provisions and all applicable requirements for provider agreements under state and federal laws, rules and regulations including, without limitation, the Medicare Advantage rules and regulations to which **Humana** is subject. In the event of a conflict between the language of such downstream agreements and the Agreement, the language in the Agreement shall control.

**t)** With respect to any Members who are eligible for both Medicare and Medicaid, **Provider** agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, **Provider** agrees to: (i) accept the payment amount from **Humana** as payment in full, or (ii) bill the appropriate State source.

**u)** **Provider** certifies that **Provider** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally-funded health care program. **Provider** shall review the Office of Inspector General and General Services Administration exclusion files and verify on a monthly basis (or as often as required by CMS) that the persons it employs or contracts for the provision of services under the Agreement are in good standing. **Provider** shall notify **Humana** immediately upon becoming aware that **Provider** or its principals, employees, agents, or subcontractors have been excluded, suspended, or debarred from participation in any federally-funded health care program.

**MEDICAID REQUIRED PROVISIONS ATTACHMENT**

The following additional provisions apply specifically to **Humana's** Kentucky Medicaid products and plans and are hereby incorporated by reference into the Agreement. In the event of a conflict between the terms and conditions of the Agreement and this Medicaid Required Provisions Attachment ("Attachment"), the terms and conditions of this Attachment shall control as they apply to **Humana's** Kentucky Medicaid products and plans.

1. This Attachment sets forth the rights, responsibilities, terms and conditions governing the **Provider's** participation in **Humana's** Kentucky Medicaid products and plans.

2. **Provider** agrees to provide "Covered Services" to **Humana** Kentucky Medicaid Members (solely for purposes of this Attachment hereinafter referred to as "Member(s)") in accordance with all applicable federal and state laws, rules, regulations, and policies and procedures relating to the provision of medical services rendered to such Members. For purposes of this Attachment, the term "Covered Services" means those Medically Necessary services which a Member is eligible to receive pursuant to their enrollment in a **Humana** Kentucky Medicaid product or plan.

3. **Provider** agrees that he, she or it is enrolled as a participating provider in the Kentucky Medicaid Program and will maintain at all times during the term of the Agreement a current provider participation agreement and Medicaid provider number with the Kentucky Department for Medicaid Services or its designated agent.

4. **Provider** agrees to indemnify and hold harmless the Commonwealth of Kentucky, the Kentucky Cabinet for Health and Family Services, the Kentucky Department for Medicaid Services, its officers, agents, and employees, and each and every Member from all claims, demands, liabilities, suits, judgments, or damages, including court costs and attorneys' fees, brought against such persons or entities because of **Provider's** failure to pay any debt or fulfill any obligation.

5. **Provider** agrees to maintain such records, including electronic storage media, as are necessary to document the extent of services furnished to Members for a minimum of five (5) years or as otherwise required by state and federal laws, and for such additional time as may be necessary in the event of an audit, quality of care issue, or other dispute, and to furnish **Humana** and authorized state and federal agencies with any information requested regarding payments claimed for furnishing services under a **Humana** Kentucky Medicaid product or plan. **Provider** further agrees to permit representatives of the state and federal government an unrestricted right to examine, inspect, copy and audit all records pertaining to the provision of services furnished to Members. Such examinations, inspections, copying and audits may be made without prior notice to **Provider**. This right shall include the ability to interview **Provider's** staff during the course of any inspection, review, investigation or audit.

6. **Provider** agrees to comply with the Civil Rights requirements set forth in 45 C.F.R. Parts 80, 84, and 90 and the Americans with Disabilities Act, 42 U.S.C. § 12101. Payments will not be made to **Provider** in the event **Provider** is found to have discriminated on the basis of race, color, national origin, sex, disability, religion, age or marital status in the provision of services.

7. **Provider** agrees to cooperate with applicable public health agencies to coordinate appropriate medical care for Members in order to ensure quality of care and to avoid the provision of duplicate or unnecessary medical services.

8. **Provider** assures that he, she or it is aware of, and shall comply with, the provisions of 42 U.S.C. § 1320a-7b, and of the provisions of KRS 205.8451 to KRS 205.8483 relating to Medicaid program fraud and abuse, and applicable Kentucky Administrative Regulations as specified in Title 907.

9. **Provider**, upon request, agrees to disclose to **Humana**, in writing, all, direct or indirect, individual beneficial holders of ownership in **Provider**, all persons under the control of **Provider**, all subsidiaries, and all entities under common ownership or control with **Provider**. **Provider** agrees to inform **Humana**, and any appropriate state or federal agency to which they are required to report, within thirty-five (35) days of any change in **Provider's** name, ownership, control or address; and, within five (5) days of information concerning **Provider's** change in licensure or certification, regulation status, criminal charges, or

disciplinary action against **Provider** by the applicable professional association or other professional review body or society.

10. **Provider** further agrees to assume full responsibility for appropriate, accurate and timely submission of claims and encounter data consistent with applicable laws, regulations, and Medicaid instructions, whether submitted directly by **Provider** or by its agents or subcontractors.

11. **Provider** agrees that any information submitted by **Provider** to **Humana** under the Agreement is true, accurate and complete, and any subsequent correction which alters such information will be transmitted promptly. **Provider** acknowledges and understands that payment and satisfaction of claims will be, in whole or in part, from federal and state funds, and that any false claims, statements, or documents or concealment of falsification of a material fact, may be prosecuted under applicable federal and state law.

12. **Provider** agrees to participate in any **Humana** Kentucky Medicaid product or plan quality assurance program or any other quality assurance program to which **Provider** is required to participate by state or federal law, and understands that the data generated from any such program will be used for analysis of medical services provided to assure quality of care according to professional standards.

13. **Provider** agrees that a contract for the sale or a change of ownership in, or controlling interest of, **Provider** shall specify whether the buyer or seller is responsible for any amounts that may be owed to **Humana** by **Provider**, regardless of whether the amounts have been identified at the time of sale or the change of ownership or controlling interest. In the absence of such specification in the contract for the sale or the transaction involving the change of ownership of or controlling interest in **Provider**, the owners or the partners at the time **Humana** made an overpayment have the responsibility for liabilities arising from such overpayments, regardless of when identified.

14. **Provider** agrees that failure of **Provider** to comply with the terms of the Agreement applicable to **Humana's** Kentucky Medicaid products and plans may result in the initiation of the following sanctions: (a) freezing Member enrollment with **Provider**; or (b) if applicable, **Humana's** referral of **Provider** to the Office of Inspector General for investigation of potential fraud or quality of care issues. **Humana** may allow **Provider** two (2) weeks to cure any violation that could result in the sanctioning of **Provider**. If **Provider** does not or refuses to cure the violation, **Humana** will report the action to the appropriate professional boards and agencies, as applicable.

15. **Provider** agrees to notify **Humana** and any appropriate state or federal agency to which they are required to report in writing of having filed for protection from creditors under the Bankruptcy Code within five (5) days of having filed a petition with the court. Notification shall include the number assigned the case by the court, and the identity of the court in which the petition was filed.

16. **Provider** certifies that **Provider** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally-funded health care program. **Provider** shall notify **Humana** immediately upon becoming aware that **Provider** or its principals, employees, agents, or subcontractors have been excluded, suspended, or debarred from participation in any federally-funded health care program.

17. **Provider** agrees to comply with the policies and procedures set forth in **Humana's** provider manual applicable to Kentucky Medicaid, any other applicable **Humana** policies and procedures, and any Kentucky Medicaid Program services manual or manuals applicable to **Provider**, the provisions of which are incorporated by reference herein.

18. **Provider** agrees to comply with all applicable requirements of the Deficit Reduction Act of 2005, Section 6032, including employee education for false claims recovery.

19. **Provider** agrees that payment by **Humana** for Covered Services rendered to a Member shall be considered payment in full. **Provider** further agrees that: (a) a bill for the same service shall not be tendered to a Member; (b) a payment for the same service shall not be tendered to a Member; and (c) a payment for the same service shall not be accepted from a Member.

20. **Provider** agrees not to bill a Member for Covered Services, with the exception of applicable co-pays or other cost sharing requirements, or for a bill that was denied due to incorrect billing. **Provider** may bill a Member for a service not covered by the applicable **Humana** Kentucky Medicaid product or plan, provided the Member was previously informed of the non-covered service and agreed in advance in writing to pay for such service.

21. **Humana** shall immediately terminate **Provider's** participation in **Humana's** Kentucky Medicaid products or plans if Medicare or Medicaid terminates **Provider**.

22. **Provider** agrees to schedule, as applicable, outpatient follow up and/or continuing treatment prior to discharge of all Members receiving inpatient psychiatric services.

23. The following provisions apply solely to the persons or entities specified below:

    (a) If **Provider** is a specialty hospital providing psychiatric services to persons age twenty-one (21) and under, **Provider** shall be approved by the Joint Commission on Hospitals or the Council on Accreditation of Services for Families and Children or any other accrediting body with comparable standards that are recognized by Kentucky. In the event **Provider** is a general hospital, **Provider** shall be certified for participation under Title XVIII of the Social Security Act or the Joint Commission on Accreditation of Health Care Organizations.

    (b) If **Provider** renders Home Care Waiver Services, **Provider** agrees to comply with the conditions for participation established under 907 KAR 1:070. **Provider** and its staff shall meet all training requirements prior to providing such services.

    (c) If **Provider** renders services under Personal Care Assistance Programs, **Provider** agrees to comply with the conditions for participation established in 907 KAR 1:090. **Provider** and its staff shall meet all training requirements prior to providing such services.

    (d) If **Provider** is a long term care facility (NF, ICF/MR or mental hospital), or if **Provider** renders home community based waiver services (HCB, SCL, Model Waiver II, Acquired Brain Injury, etc.), as a result of the Medicare Catastrophic Coverage Act of 1988, each **Provider** providing long term care services agrees to advise all new admissions of resource assessments to assist with financial planning performed by the Kentucky Department for Community Based Services through a contractual arrangement with the Kentucky Department for Medicaid Services.

    (e) If **Provider** is a nursing facility, **Provider** agrees to comply with the preadmission screening and resident review requirement specified in Section 1919 of the Social Security Act.

    (f) If **Provider** is required to participate or hold a certification under Title XVIII of the Social Security Act to provide Title XIX services, **Provider** assures such participation or certification is current and active.

## PRIMARY CARE PROVIDER ("PCP")

## RESPONSIBILITIES ATTACHMENT

This attachment applies solely to a **Provider** who may serve as a PCP for **Humana's** Kentucky Medicaid Members in accordance with Kentucky Medicaid laws, regulations, rules and/or guidelines. Unless otherwise specified by applicable Kentucky Medicaid laws, regulations, rules and/or guidelines, for purposes of this attachment a PCP includes, but is not limited to, a physician, an advanced practice registered nurse, a physician assistant, or clinic (including a federally qualified health center, primary care centers and rural health clinics).

**Provider** agrees to:

1. Supervise, coordinate, and provide initial, primary and preventative care, including EPSDT services.

2. Provide or arrange for the provision of Covered Services on a routine, urgent, and emergency care basis for Members.

3. Accept Members without discrimination or screening of such Members based upon their health status.

4. Be responsible twenty-four (24) hours a day, seven (7) days a week for providing, prescribing, directing and authorizing all Covered Services, including all urgent and emergency care.

5. Maintain and provide to **Humana** a description of formalized arrangements with other PCPs to refer Members for urgent and emergency care and service coverage in the event **Provider** or another PCP is unavailable due to vacation, illness or after-hours or for other reasons to extend **Provider's** practice, and will assure that the PCP providing coverage will provide services under the same terms and conditions and in compliance with all provisions of the Agreement. **Provider** shall be responsible for any and all compensation for such other PCP(s). Neither **Provider** nor the PCP(s) providing coverage shall seek additional compensation from **Humana** or Members for services rendered.

6. Issue referrals for Members in accordance with **Humana's** referral guidelines.

7. Maintain hospital admitting privileges or a formal referral agreement with a PCP who participates with Kentucky Medicaid and has hospital admitting privileges.

8. Have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problem or disorder.

9. Within ten (10) days from receipt of request, transfer the medical records of a Member to a new PCP when the Member changes PCPs.

10. Not to request the reassignment of a Member to a different PCP for the following reasons:

    (a) A change in the Member's health status or treatment needs;
    (b) A Member's utilization of health services;
    (c) A Member's diminished mental capacity; or
    (d) Disruptive behavior of a Member due to the Member's special health care needs unless the behavior impairs the PCP's ability to provide services to the Member or others.

11. Not to base a PCP change request on race, color, national origin, disability, age or gender. **Provider** agrees that **Humana**, in its sole discretion, shall have the authority to approve or deny a PCP change.

12. Maintain:

    (a) Continuity of a Member's health care; and
    (b) A current medical record for a Member in accordance with applicable federal and state law requirements as well as **Humana's** provider manual applicable to Kentucky Medicaid.

13. Refer a Member for specialty care and other medically necessary services, both in and out of network, if the services are not available within **Humana's** Kentucky Medicaid provider network.

14. Discuss advance medical directives with a Member.

15. Refer a Member for a behavioral health service if clinically indicated.

16. Have an after-hours phone arrangement that ensures that a PCP or a designated medical practitioner returns the call within thirty (30) minutes.

**HMO PROVISIONS**
**ATTACHMENT**

**The following provisions apply to HMO products and plans, as applicable.**

**I.** **Services to Members**. In the event **Provider** provides a Member a non-covered service or refers a Member to an out-of-network provider without pre-authorization from **Humana**, **Provider** shall, prior to the provision of such non-covered service or out-of-network referral, inform the Member: (i) of the service(s) to be provided or referral(s) to be made; (ii) that **Humana** will not pay or be liable financially for such non-covered service(s) or out-of-network referral(s); and (iii) that Member will be responsible financially for non-covered service(s) and/or out-of-network referral(s) that are requested by the Member.

**II.** **Continuity of Care**. Subject to and in accordance with all applicable state and/or federal laws, rules and/or regulations, treatment following termination or expiration of this Agreement must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Member; and (ii) until the date of discharge for Members hospitalized on the effective date of termination or expiration of this Agreement. **Provider** agrees to accept as payment in full from **Humana** for Covered Services rendered to such Members, the rates set forth in the Payment Attachment, less any Copayments due from such Members.

**III.** **Provider Responsibilities**.

**A. Services**

**Provider** agrees to be responsible twenty-four (24) hours a day, seven (7) days a week for providing Covered Services for Members.

**B. Specific Referrals**

Except in the case of a medical emergency, **Provider** agrees to use its best efforts to admit, refer, and cooperate with the transfer of Members for Covered Services only to providers designated, specifically approved by or under contract with **Humana**.

In addition, **Provider** acknowledges and agrees that certain Members may have health benefits contracts that limit coverage to certain types of participating providers. For such Members, referrals are required to be made to specific providers designated by **Humana**.

**C. Disease/Case Management Programs**

**Provider** agrees to participate in **Humana's** disease/case management programs as they are developed and implemented.

**D. Hospitalist Programs**

**Provider** agrees to cooperate with and participate in **Humana's** hospitalist programs where applicable, as they are developed and implemented.

**E. Transplant Programs**

Upon request by **Humana**, **Provider** agrees to cooperate with and participate in **Humana's** organ and tissue transplant programs as they are developed and implemented.

**F. Humana First**

**Provider** agrees to participate in **Humana's** twenty-four (24) hour nurse call program, HumanaFirst, or any such successor program.

**G. Health Improvement Studies**

**Provider** agrees to participate in **Humana's** health improvement studies as they are developed and implemented.

## H. Quality Improvement Activities

**Provider** agrees to cooperate with **Humana's** quality improvement activities and, upon request by **Humana**, to participate in **Humana's** quality improvement activities as they are developed and implemented.

## HUMANA'S UTILIZATION REVIEW PROGRAM ATTACHMENT

**Humana** interventions can occur throughout the continuum of care. The channels for that engagement can include telephone, on-site engagement and written communication. **Provider** agrees to participate in and cooperate with **Humana's** utilization review program that includes, but is not limited to, the following processes:

1. **Provider** agrees to verify that the Member's physician has obtained pre-authorization approval of the admission from **Humana** for all non-emergency admissions and surgical cases.

2. **Provider** agrees to notify **Humana's** admission review department of all admissions within twenty-four (24) hours of admission.

3. **Provider** agrees to notify **Humana** on a daily basis, of Members who have been discharged or transferred from **Provider**.

4. **Provider** agrees to obtain authorization from Members at time of admission for the **Provider** to release medical records to **Humana** and for **Humana's** review personnel to review the Member's medical records during hospitalization and after discharge.

5. **Provider** agrees to allow **Humana** review personnel to have access to Member's medical records and to Members to undertake concurrent review. This access can be either telephonic or on site.

6. **Provider** agrees to cooperate with **Humana's** review personnel in discharge planning for Members.

7. **Provider** agrees to make adequate space available, when needed, in the medical records department for **Humana's** review personnel to carry out review activities or cooperate with telephonic reviews. **Provider** agrees to allow **Humana** access to electronic records when that is the only way to view a medical record.

8. Upon discharge of Members, **Provider** agrees to submit a completed claim form, in the format specified in the Agreement for each Member to **Humana** with the admitting and discharge diagnosis recorded and coded.

9. **Provider** agrees to allow **Humana's** review personnel to photocopy any portion of the medical records of Members.

10. **Provider** agrees to release copies of medical records to **Humana** of Members who have been discharged from **Provider** for retrospective review and special studies.

# PAYMENT ATTACHMENT